

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 760

1. PLACE OF DEATH:

County SomersetCity or town Manskin
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Manskin Md
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Cornie S. Brown

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Joseph Brown7. Birth date of deceased (mo., day, yr.) April 4, 1862 6. (c) If alive, give age _____ years8. AGE: Years 83 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Revels Neck
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name Frank Long13. Birthplace Revels Neck14. Maiden name Sena Bowman15. Birthplace Revels Neck16. Informant Mr William Mc LaneAddress Manskin, Md.17. Burial Date thereof Nov 8, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Presbyterian CemeteryLocation Princess Anne, Md.18. Funeral director Dale DashiellAddress Princess Anne, Md.19. Nov. 6, 45 R. H. Johnson, M.D.
(Date rec'd by registrar) (Registrar)Per gnd.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mr 6 19 45 at 7 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mr 1 19 44 to Mr 6 19 45
and that I last saw him alive on Mr 2 19 45

Immediate cause of death

Cornie BrownDue to acute infarctDue to acute infarctOther conditions acute infarct

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Cornie Brown, M.D. M. D. or otherAddress Manskin, Md. Date signed Nov 6, 45

11343

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NOV 8 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 270

1. PLACE OF DEATH:

County Somerset
 City or town Crisfield, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 hrs
 Hospital, institution, or street address where death occurred:
Mc Crady Memorial Hospital
 How long in hospital or institution? 3 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset
 City or town Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Infant Dashiell

3. (b) Social Security Number

None

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced.

B. (b) Name of husband or wife

B. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Nov 9 1945

8. AGE:

Years

Months

Days

If less than one day

3 hrs. _____ min.

9. Birthplace

Crisfield Somerset Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Jarvis Dashiell

13. Birthplace

Kingston, Maryland

14. Maiden name

Lillian Hilbert

15. Birthplace

Crisfield Maryland

16. Informant

Address

Mc Crady Hospital
Crisfield, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

St Paul Cemetery

Location

Maryland State, Maryland

18. Funeral director

Address

John P. Bradshaw Jr.
Crisfield, Md.

19.

(Date Rec'd by registrar)

19

11/10/45
C. E. Collins M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 1945 at 8:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 9 1945 to Nov 9 1945and that I last saw him Nov 9 1945

Immediate cause of death

Infantile Choked death
no milk

DURATION

Due to

Asphyxia due to2 hrs

Due to

Asphyxia - milk

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

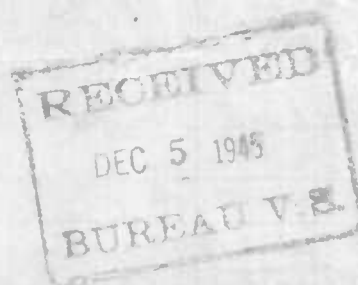
Garvis Dashiell M.D.
M. D. or other

Address

Maryland State

Date signed

Nov 10 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93D

CERTIFICATE OF DEATH

Reg. Dist. No. 11344 260

1. PLACE OF DEATH:

County SomersetCity or town Mt. Vernon
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?.....
Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Mt. Vernon, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Cadmus Washiell

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MWmarried6. (b) Name of husband or wife Jennie Washiell6. (c) If alive, give age 88 years7. Birth date of deceased (mo., day, yr.) Sept. 17 18588. AGE: Years Months Days If less than one day
87 1 21 hrs. min.8. Birthplace Mt. Vernon, Md.
(Town, county, and state)10. Usual occupation mail carrier

11. Industry or business

FATHER 12. Name Edgar Washiell13. Birthplace Mt. Vernon, Md.MOTHER 14. Maiden name Edith Webster15. Birthplace Mt. Vernon, Md.16. Informant Mrs. Jennie WashiellAddress Mt. Vernon, Md.17. Burial Date thereof Nov. 6, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Presbyterian CemeteryLocation Princess Anne, Md.18. Funeral director Walter WashiellAddress Princess Anne, Md.19. Nov. 6 45 R. H. Johnson, M.D.
(Date rec'd by registrar) Registrar Per g.d.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4th 1945 at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to..... 19.....

and that I last saw him live on 19.....Immediate cause of death Dysentery

Due to.....

Due to.....

Other conditions Cholera

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Johnson M. D. or otherAddress Princess Anne, Md. Date signed 11/5-45

RECEIVED

NOV 8 1945

RECEIVED

NOV 8 1945

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1912

CERTIFICATE OF DEATH

★ Reg. Dist. No. 265

1. PLACE OF DEATH:

County..... **Somerset**
 City or town..... **Crisfield**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... **53 years**
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... **Maryland** County..... **Somerset**
 City or town..... **Crisfield**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... **320 Pine Street**
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Maude Arintha Daugherty

3. (b) Social Security Number

4. Sex..... **Female** 5. Color or race..... **White** 6. (a) Single, married, widowed, or divorced..... **Widowed**
 6. (b) Name of husband or wife..... **Harry Daugherty**
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... **August 15, 1892**
 8. AGE: Years..... **53** Months..... **3** Days..... **8** If less than one day..... **3** hrs. min.

9. Birthplace..... **Crisfield-Somerset-Maryland**
 (Town, county, and state)

10. Usual occupation..... **House wife**

11. Industry or business

FATHER
 12. Name..... **James B. Ward**
 13. Birthplace..... **Crisfield, Maryland**
MOTHER
 14. Maiden name..... **Charlotte Dizeyland**
 15. Birthplace..... **Crisfield, Maryland**

16. Informant..... **Mrs. Rawdon Whittington**
 Address..... **Pine St., Crisfield, Md.**

17. Burial Date thereof..... **Nov. 25, 1945**
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium..... **Crisfield Cemetery**
 Location..... **Crisfield, Maryland**

18. Funeral director..... **H. Harvey Bradshaw**
 Address..... **Crisfield, Maryland**

19. **11/24/45** 19..... **6 E. Collins, M.D.**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **Nov 28 1945 2:30 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
August 1 1945 to Nov 23 1945
 and that I last saw him alive on **Nov 22 1945**

Immediate cause of death..... **Cerebral Occlusion**
with 2d stroke

Due to..... **Cerebral Infarction**

Due to..... **General Arterio Sclerosis**

Other conditions..... **Impaired Heart**
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... **James E. Collins**
 M. D. or other

Address..... **Maryland** Date signed..... **Nov 24 1945**

RECEIVED

DEC 5 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of age is shown on is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of age is shown on G 99 11-29-45

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 83-1

CERTIFICATE OF DEATH

11347

★ Reg. Dist. No. 260

1. PLACE OF DEATH:

County Somerset
City or town Upper Fairmount
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all of life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Mabel Grace Dorsey

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
7. Birth date of deceased (mo., day, yr.) July 24, 1881 8. (c) If alive, give age 67 years
8. AGE: Years 64 Months 03 Days 28 It less than one day
hrs. min.

9. Birthplace Upper Fairmount, Md
(Town, county, and state)10. Usual occupation Domestic

11. Industry or business

12. Name William White13. Birthplace Maryland14. Maiden name Sallie Holland15. Birthplace Maryland16. Informant Carl M. DorseyAddress Upper Fairmount17. Burial Date thereof Nov. 25, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Family burying lotLocation Upper Fairmount, Md18. Funeral director Harry B. MilesAddress Upper Fairmount, Md19. Nov 24 45 R. H. Johnson MD
(Date rec'd by registrar) Registrar

Per g.d.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22nd 1945 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to 19.....

and that I last saw h. alive on 19.....Immediate cause of death Cerebral Paralysis DURATION 2 years
Cerebral Paralysis

Due to.....

Due to.....

Other conditions.....

(Including pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

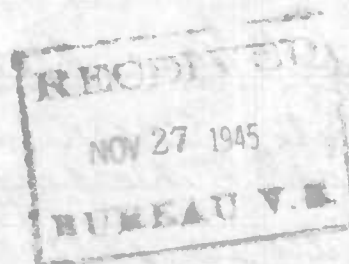
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

SIGNATURE.....

Address..... M. D. or other

Date signed 11/24/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

11348

★ Reg. Dist. No. *ELF*

1. PLACE OF DEATH:

County *Somerset*
 City or town *Shelton Md.*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *50 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution? *—*

3. (a) FULL NAME

Milton J. Gray

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Dec 21, 1890

8. AGE:

Years

Months

Days

If less than one day

*54**10**11*

hrs.

min.

9. Birthplace

Shelton Somerset Md.
(Town, county, and state)

10. Usual occupation

Waterman

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

*45**—**Ms**Gray**J. Wilson**Registrator**Nov 3**19**45**—**Ms**Gray**J. Wilson**Registrator**Nov 3**19**45**—**Ms**Gray**J. Wilson**Registrator**Nov 3**19**45**—**Ms**Gray**J. Wilson**Registrator**Nov 3**19**45**—**Ms**Gray**J. Wilson**Registrator**Nov 3**19**45**—**Ms**Gray**J. Wilson**Registrator*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Somerset*City or town *Shelton Md.*
(If outside city or town limits, write RURAL and give nearest town)Street No. *—*
(If rural, give LOCATION)2. (a) If veteran, name war *—*

MEDICAL CERTIFICATION

20. DATE OF DEATH *November 1, 1945* at *3:30 P*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1 19 *45* to *Nov 2* 19 *45*and that I last saw him *—* alive on *Nov 2* 19 *45*Immediate cause of death *Acute D. of Heart**Crowning Thrombosis*Due to *—*Due to *General Arteriosclerosis*Other conditions *—*

(Include pregnancy within 3 months of death)

Major findings of operations *—*Date of op. *—*Autopsy results *—*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *—* Date of *—*Where did injury occur? *—* (City or town) (County) (State)Injured at home, farm, industry, public place (where?) *—*Means of injury *—* Injured at work? *—*23. SIGNATURE *Guay C. Douthett Md*

M. D. or other

Address *Maryland Md* Date signed *Nov 3, 1945*

RECEIVED

NOV 6 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

Reg. Dist. No. 270

1. PLACE OF DEATH
 County Somerset
 City or town Crisfield RFD
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 77 yrs
 Hospital, Institution, or street address where death occurred:
Crisfield, Md. RFD
 How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State md County Somerset
 City or town Crisfield, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME
William James Handy
 4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

3. (b) Social Security Number

None

6. (b) Name of husband or wife Elizabeth R. Handy
 B. (c) It alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) April 26, 1868

8. AGE: Years 77 Months 6 Days 13 It less than one day _____ hrs. _____ min.

9. Birthplace Crisfield Somerset Maryland
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name William Handy

13. Birthplace Somerset County

14. Maiden name Julia Lankford

15. Birthplace Somerset County

18. Informant Robert Handy

Address Crisfield, Md. RFD

17. Burial Date thereof Nov 11, 1945
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Private Cemetery

Location Crisfield, Maryland RFD

18. Funeral director John J. Buddsawyer

Address Crisfield Md.

19. 11/11/45 19 6. E. Collins, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 19 45 at 12:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____

and that I last saw him, _____ alive on _____ 19 _____

Immediate cause of death _____

Organic Heart & _____

Kidney Disease _____

Due to _____

He was dead _____

Due to _____

When I saw him _____

Other conditions _____

Natural Cause _____

Major findings of operations _____

Autopsy results none Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to violence, state the cause, date, and place of occurrence.

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (state)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wm H. Coulbourn, M.D.

Crisfield, Md. M.D. or other _____

Address _____ Date signed 11-18-45

RECEIVED
NOV 15 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 268

1. PLACE OF DEATH:

County SouthernCity or town Deal Island Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Willie J. Jones

3. (b) Social Security Number

4. Sex Male5. Color or race Blk6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Blanche Jones

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age 69 years8. AGE: 69 Years - Months 7 Days - hrs. - min.9. Birthplace Deal Island
(Town, county, and state)10. Usual occupation Waterman11. Industry or business "12. Name John Jones13. Birthplace Maryland14. Maiden name Margaret Jones15. Birthplace Maryland16. Informant Frank ParkerAddress Deal Island17. Burial Date thereof Nov. 26 - 45
(Burial, cremation, or removal, which?) (month) (day) (yr.)Cemetery or crematory John W. & M. E.Location Deal Island18. Funeral director R. J. RobertsAddress Deal Island19. Nov 26 19 45 Rosa Nehls
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24th 19 45 at 9:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 41 to Nov 16 19 45 and that I last saw him alive on Nov 16 19 45Immediate cause of death generalized arteriosclerosis

DURATION

Due to Hypertension

Due to.....

Other conditions arteriosclerosisbut Duesel

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Frank Matus MD

M. D. or other

Address Princeton, N.J. Date signed Nov 25

RECEIVED
DEC 5 1945
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1315)

11351

CERTIFICATE OF DEATH

Reg. Dist. No. 270

1. PLACE OF DEATH:

County SomersetCity or town Crisfield Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 5 days

3. (a) FULL NAME

Charles A. Lauckford Sr.4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Married8. (b) Name of husband or wife Mrs. Mary Lauckford6. (c) If alive, give age 69 years7. Birth date of deceased (mo., day, yr.) Apr. 28, 18638. AGE: Years 82 Months 6 Days 13 If less than one day

hrs. min.

9. Birthplace Somerset Co. Md.
(Town, county, and state)10. Usual occupation Canning

11. Industry or business

12. Name Louis Lauckford13. Birthplace Md.14. Maiden name Mary Lauckford15. Birthplace Md.16. Informant Mrs. Mary LauckfordAddress Upper Fairmount17. Burial St. Stephens Date thereof Nov. 14, 1945
(Burial, cremation, or removal, which) (month) (day) (year)Cemetery or crematory St. StephensLocation Upper Fairmount18. Funeral director Harry B. MilesAddress Upper Fairmount, Md.19. Nov 12 19 45 W. E. Nelson
(Date rec'd by registrar) (Year) (Month) (Day) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Upper Fairmount SomersetCity or town Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 19 45 at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1 19 45 to Nov 11 19 45and that I last saw him alive on Nov 11 19 45Immediate cause of death Uremia Acute Dec 2. renalDUE TO Chronic renalDUE TO Chronic renalOther conditions Chronic

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE George C. Coulbourn M.D.Address Marion St. Md.Date signed Nov 13 1945

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

RECEIVED
DEC 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

Reg. Dist. No. 11352 265

1. PLACE OF DEATH:

County Somerset
 City or town Rural, Crisfield, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 78 yrs.
 Hospital, institution, or street address where death occurred:
Johnson Creek Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Somerset
 City or town Rural Crisfield Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Johnson Creek Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Derrick K. Lawson

3. (b) Social Security Number

218-14-254

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Nellie J. Lawson
 6.(c) If alive, give age 71 years
 7. Birth date of deceased (mo., day, yr.) Sept. 17, 1867
 8. AGE: Years 78 Months I Days 29 If less than one day
hrs.min.

9. Birthplace Crisfield, Somerset, Md
 (Town, county, and state)

10. Usual occupation Waterman

11. Industry or business Retired Waterman

12. Name John J. Lawson

13. Birthplace Crisfield, Somerset, Md

14. Maiden name Hettie E. Sterling

15. Birthplace Crisfield, Somerset, Md.

16. Informant Nellie J. Lawson

Address Johnson Creek Road, Crisfield, Md

17. Burial Nov. 18, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sunny Ridge Cemetery

Location Crisfield, Md

Howard H. Hubbard

18. Funeral director

Address 306 Main St. Crisfield, Md

19. 11/17/45 19 6. E. Callum
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1945 19 45 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 10 19 45 to Nov 15 19 45

and that I last saw him alive on Nov 10 19 45

Immediate cause of death Coronary Atherosclerosis DURATION 12 hr.

Due to Coronary Atherosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. W. Peyton M.D. M. D. or other

Address Crisfield, Md Date signed Nov. 17, 1945

RECEIVED

DEC 5 1945

BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11353

Reg. Dist. No. 270

FILM No. I O O JAN 11 1946

1. PLACE OF DEATH Somerset

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

William Luettinger

3.(b) Social Security Number

none

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Phylis K.

7. Birth date of deceased (mo., day, yr.)

Sept. 20, 1875

8.(c) If alive, give age years

70

8. AGE:

Years

Months

Days

If less than one day

70

71-

2

9

hrs.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual occupation

Retire Frsmer

11. Industry or business

Self

FATHER

12. Name

William Luettinger

13. Birthplace

Germany

MOTHER

14. Maiden name

Elizabeth Mentzel

15. Birthplace

Germany

16. Informant

Phylis K. Luettinger

Address

RFD Marion Station

17.

(Burial, cremation, or removal. Which?)

Date thereof

Dec. 2, 1945

(month) (day) (year)

Cemetery or crematory

Sunny Ridge

Location

Crisfield, Md.

Howard H. Hubbard

18. Funeral director

Address

506 Main St., Crisfield, Md.

19.

(Date rec'd by registrar)

19

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29, 1945, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 24, 1945, to Nov. 27, 1945, and that I last saw him alive on Nov. 27, 1945.

Immediate cause of death

Acute myocardial

failure

Due to Chronic myocarditis

Due to Coronary sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

S. M. Peyton M.D.

Address Crisfield, Md.

Date signed Dec 1, 1945

RECEIVED
DEC 27 1945
BUREAU OF INDIAN AFFAIRS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 11354 265

1. PLACE OF DEATH:

County SomersetCity or town Crisfield
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? ?

Hospital, institution, or street address where death occurred:

Paper StHow long in hospital or institution? ?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W.D. County SomersetCity or town Crisfield
(If outside city or town limits, write RURAL and give nearest town)Street No. 8 Paper St

(If rural, give LOCATION)

2. (a) If veteran, name war ?

3. (a) FULL NAME

Comer Miles

3. (b) Social Security Number

?4. Sex M5. Color or race C

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Martha Jane Miles7. Birth date of deceased (mo., day, yr.) 1882 ? ?B. (c) If alive, give age ? years8. AGE: Years 63 Months ? Days ? If less than one dayhrs. ? min. ?9. Birthplace Crisfield, Somerset, W.D.
(Town, county, and state)10. Usual occupation Seaford Laborer

11. Industry or business

12. Name Alfred Miles13. Birthplace Somerset County14. Maiden name Isabell Carter15. Birthplace Somerset County16. Informant Laura WattsAddress Crisfield, W.D.17. Burial Date thereof Nov. 28, 1945

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Lawsonia Cem.Location Lawsonia W.D.18. Funeral director John A. Bradshaw Jr.Address Crisfield W.D.19. 11/26/45 19 45(Date rec'd by registrar) Registrar G. E. Collins, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 19 45 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 10 19 45 to Nov. 23 19 45and that I last saw him alive on Nov. 23 19 45Immediate cause of death ComaDURATION 11/10/45To 11/24/45Due to Interstitial Nephritis, chronicDuration: Infection & AlcoholDue to Several yearsDue to Chronic

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE W. J. Barkley, D.D.

M. D. or other

Address 309 W. Ind. Ave.Date signed 11/24/45

RECEIVED

DEC 5 1945

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Ba*

CERTIFICATE OF DEATH

11355

★ Reg. Dist. No. 270

1. PLACE OF DEATH: **Somerset**
 County.....
 City or town..... **Crisfield**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... **70 yrs**
 Hospital, institution, or street address where death occurred:
 **McCready Memorial**
 How long in hospital or institution?..... **3 months**

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... **Ma.** County..... **Somerset**
 City or town..... **Crisfield**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... **First St.**
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... **none**

3. (a) FULL NAME
Walter C. Parker

3. (b) Social Security Number
none

4. Sex **Male** 5. Color or race **white** 6. (a) Single, married, widowed, or divorced **widow**

6. (b) Name of husband or wife..... **Eletia A.**

7. Birth date of deceased (mo., day, yr.)..... **Mar. 1, 1856**

8. AGE: Years Months Days If less than one day
89 **8** **6** hrs. min.

9. Birthplace..... **Virginia**
 (Town, county, and state)

10. Usual occupation..... **Retired Waterman**

11. Industry or business..... **Self**

FATHER 12. Name..... **Josiah Parker**

13. Birthplace..... **Va.**

MOTHER 14. Maiden name..... **Mateldia Bundick**

15. Birthplace..... **Va.**

16. Informant..... **Margaret Dize**

Address..... **Locust St., Crisfield, Md.**

17. Burial Date thereof..... **11/8/45**
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... **Crisfield Cemetery**

Location..... **Crisfield, Md.**

Howard H. Hubbard

18. Funeral director..... **306 Main St., Crisfield, Md.**

Address.....

19. **11/7/45** **C. E. Callum M.D.**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **November 5, 1945** at **8 P.** M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Sept. 1945** to **Nov. 5, 1945**

and that I last saw him alive on **Nov. 5, 1945**

Immediate cause of death..... **cardio-vascular - renal disease** DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... **C. E. Callum M.D.** M. D. or other

Address..... **Crisfield** Date signed **Nov. 6/45**

RECEIVED THE BUREAU OF HEALTH

STANDARD 17 150 100

RECEIVED

DEC 5 1945

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83-2

11356

CERTIFICATE OF DEATH

Reg. Dist. No. 268

1. PLACE OF DEATH:

County SomersetCity or town Deal Island
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Thomas Scott

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Willie Scott7. Birth date of deceased (mo., day, yr.) 1873 Not obtainable

8. (c) If alive, give age years

8. AGE: Years 73 Months - Days - It less than one day - hrs. - min.9. Birthplace Deal Island Md
(Town, county, and state)10. Usual occupation Oyster stevedore11. Industry or business "12. Name Samuel I Scott13. Birthplace Deal Island Md14. Maiden name Sarah Farmer15. Birthplace Deal Island16. Informant Mrs Thos ScottAddress Deal Island Md

17. Burial

Date thereof Nov 4th 48
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory St Johns M. C.Location Deal Island18. Funeral director St JohnsAddress Deal Island19. Nov 4th 19 48 Rosa Nechter

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Deal Island
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2nd 19 48 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 1 19 48 to Nov 2 19 48and that I last saw him alive on Nov 1 19 48Immediate cause of death Cerebral Hemorrhage

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Nechter

M. D. or other

Address Princess Anne Date signed 11/4

RECEIVED

NOV 7 1945

BUREAU V.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11357 760
Reg. Dist. No.

1. PLACE OF DEATH:

County SomersetCity or town Westover
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 22 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County SomersetCity or town Westover
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

4. Sex male 5. Color or race C 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Oct 1-1923 B.(c) If alive, give age _____ years8. AGE: Years 22 Months 1 Days 4 If less than one day _____ hrs. _____ min.9. Birthplace Westover, Somerset Co md
(Town, county, and state)10. Usual occupation Farming

11. Industry or business

12. Name Samuel Shreeves13. Birthplace Pocomoke Worcester Co md14. Maiden name Leanes Collins15. Birthplace Westover Somerset Co md16. Informant Leanes ShreevesAddress Westover md17. Burial Date thereof Nov 7 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory John WesleyLocation Westover md.18. Funeral director Chas H WardAddress Marion md.19. Nov 6 45 R.H. Johnson, M.D.
(Date rec'd by registrar) (Per g.d. Registrar)

3. (b) Social Security Number

218-12-1176

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1945, at 5 30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 31 1945 to Nov 4 1945and that I last saw him alive on Nov 3 1945Immediate cause of death Acute Dying HeartDue to Lobar Pneumonia

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Emilio P. Williams, M.D.
M. D. or otherAddress Marion Md. Date signed Nov 5 45

RECEIVED

NOV 8 1945

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 265

11358

1. PLACE OF DEATH:

County Somerset
 City or town Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Somerset
 City or town Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. N. Somerset Ave.
 (If rural, give LOCATION)
 2. (a) If veteran, name war none

3. (a) FULL NAME

John T. Sterling

3. (b) Social Security Number

none

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Cora F. Sterling
 6. (c) If alive, give age 72 years
 7. Birth date of deceased (mo., day, yr.) September 12, 1857
 8. AGE: Years 87 Months 2 Days 12 If less than one day
 hrs. min.

9. Birthplace Crisfield, Md.
 (Town, county, and state)
 10. Usual occupation Retired Lumberman
 11. Industry or business Self
 12. Name Thomas Sterling
 13. Birthplace Md.
 14. Maiden name Anna Respice
 15. Birthplace Va.

16. Informant Cora F. Sterling
 Address Crisfield, Md.

17. Burial Burial Date thereof 11/26/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Sunny Ridge
 Location Crisfield, Md.
Howard H. Hubbard

18. Funeral director 306 Main St., Crisfield, Md.
 Address

19. 11/26/45 Registrar E. E. Hubbard
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24, 1945 19 2 at 30AM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 9, 1945 to Nov. 24 19 45
 and that I last saw him alive on Nov. 23 19 45

Immediate cause of death arteriosclerosis DURATION 3+ yrs.

Due to

Due to

Other conditions pericarditis 12 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel W. Payton M.D. M. D. or other

Address Crisfield, Md. Date signed Nov. 26, 1945

RECEIVED
DEC 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18620

CERTIFICATE OF DEATH

11359

★ Reg. Dist. No. 265

1. PLACE OF DEATH: Somerset
 County.....
 City or town..... Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 How long to above place of death? 70 yrs
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Somerset
 City or town..... Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. RFD
 (If rural, give LOCATION)
 2(a) If veteran, name war none

3. (a) FULL NAME Virginia D. Sterling

3. (b) Social Security Number
 none

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife Andrew G.

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1856 8. (c) If alive, give age years

8. AGE: 89 Years Months Days It less than one day hrs. min.

9. Birthplace Pocomoke City, Md.
 (Town, county, and state)

10. Usual occupation housewife

11. Industry or business home

12. Name Harry Jones

13. Birthplace Md.

14. Maiden name Ann

15. Birthplace Md.

16. Informant Joseph Sterling

Address RFD Crisfield, Md.

17. Burial Date thereof 11/25/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ashbury

Location Crisfield

18. Funeral director Howard H. Hubbard

Address 306 Main St., Crisfield, Md.

19. 11/24/45 18 19 C. E. Collins M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 19 45 at 4A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 Nov 15 19 45 to Nov 20 19 45
 and that I last saw her alive on Nov 22 19 45

Immediate cause of death
 Acute Dec 2 Year
 Death

Due to Fall. First left arm
 1 ribs on left side

Due to

Other conditions

Chronic Dec 2 Year
 Chronic Dec 2 Year

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Guy W. O'Neil M.D.

M.D. or other

Address Merion O. M.D. Date signed Nov 24 19 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 5 1945
BUREAU V S